FY 2006 Budget Presentation

Mr. Chairman, members of the Committee,

Thank you for the opportunity to present the Medicaid budget request to you. Because of the leadership of Governor Riley and the commitment and cooperation of this body, Medicaid was funded last year with an unprecedented increase of $144 million. The challenges that were overcome last year have allowed Medicaid to continue to pay for medically necessary services for almost one million citizens of Alabama.

We, like other states around the country, continue to struggle to fund the escalating cost of health care services, particularly prescription drugs, with limited state resources. At least 22 other states now project shortfalls averaging 6 to 7.5 percent of their general fund spending. Medicaid, health care costs and other health related matters top legislative agendas in 30 states for the upcoming 2005 legislative session. Specific Medicaid concerns include the reduction in the federal matching rate and rapidly rising costs stemming from increases in eligibles, and medical cost inflation.[1]

In particular:

- Wisconsin faces a Medicaid shortfall of $800 million over the next two years
- Louisiana faces a Medicaid shortfall of $586 million
- Iowa faces a Medicaid shortfall of $181.5 million

Program Overview

As many of you know, Alabama Medicaid pays for the most limited and basic health care services to the poorest individuals. The qualifying income limit for family coverage through Medicaid for Low Income Families is the lowest in the country at $194 per month for a family of

[1] State Budget Update, National Conference of State Legislatures, November 2004.

four, currently 14% of the poverty level. Except for nursing homes, financial eligibility in other programs is set at the minimum federal requirements. We have one of the most conservative adult benefit packages in the country. Even at existing levels of service, Medicaid pays for health care services for almost 1 million people, which represents:

- 20% of Alabama's population[2]
- 37% of Alabama's children under the age of 19. Of these children, almost 47% are in families with at least one working caregiver.
- 46% of all deliveries including the prenatal care responsible for the significant decrease in the state's infant mortality rate
- 21% of seniors 65 and above
- Over 70% of all nursing home beds in Alabama are paid for by Alabama Medicaid[3]
- There are 11 counties in Alabama where 50 percent or greater of the children's population is eligible for Medicaid.[4]

In addition, Medicaid has been unable to increase reimbursement to essential providers, in many cases, for ten years or more.

Economic Impact

Medicaid has become the cornerstone of Alabama's healthcare infrastructure. Without Medicaid revenue, critical components of the State's healthcare system would not continue to exist even for those of us blessed to have private insurance. In addition, Alabama Medicaid, along with ALL Kids and the Alabama Child Caring Foundation, is responsible for healthcare

[2] FY 2004: 935,539 eligibles, 51% of Medicaid eligibles are children. 734,905 recipients; 58.5% of Medicaid recipients are children.
[3] 74% of nursing home residents in participating nursing homes, 72% of nursing home residents in ALL nursing homes
[4] Bullock (67), Butler (57.4), Conecuh (55.3), Dallas (64.5), Greene (65.1), Lowndes (55.1), Macon (50.9), Perry (66), Pike (49.5), Sumter (61.5), Wilcox (68.7).

coverage for a significant number of children -- our most vulnerable population. Alabama has one of the lowest uninsured rates for children in the country.[5] This is a sound investment for our future. Medicaid operates with one of the lowest administrative costs in the country. Over 97% of Medicaid's total budget is spent on benefits and services for our recipients. In FY 2004, administrative costs were 2.6% of total Medicaid expenditures.[6] I am unaware of any other organization or charity that operates comparable programs as efficiently.

During FY 2004, Medicaid paid over $3.7 billion to providers such as physicians and pharmacies for various health care services rendered; $2.7 billion represented federal funds brought into Alabama. In FY 2005, Medicaid will pay approximately $3.9 billion for health care services. These expenditures support more than 84,000 jobs in various industries within the state.[7] During FY 2004, 5 Alabama counties received more than $100 million in Medicaid payments.[8]

52% of the patient days at Children's Hospital are paid for by Medicaid; 77% of the patient days at USA Children's and Women's Center are paid for by Medicaid. Not only are we paying for the care received by our recipients, we also are providing resources for equipment and other items used by all patients.

Without question, the challenge of how to fund the most basic health care needs of low income children and adults who qualify for Medicaid represents one of the most critical issues to

[5] Department of Public Health Survey, 2003, Funded by the Health Resources and Services Administration. Alabama's uninsured rate was 11.2% at the time of the survey. 8.8% of Alabamians were uninsured for the entire 12 month survey period. Alabama's average is approximately 4% below the national average.
[6] 1.1% of the administrative cost is for traditional administrative expenses of staff and overhead.
1.5% of administrative cost is associated with contracts, Non-Emergency Transportation (NET) program, and Education Administrative Claiming.
[7] Economic Impact of the Alabama Medicaid Agency on the Economy of the State of Alabama and its Counties, Amy K. Yarbrough, MSHA, MBA, Administrative Fellow, University of Alabama at Birmingham, 2002.
[8] Jefferson ($496.2 million), Mobile ($267.9 million), Tuscaloosa ($149.6 million), Madison ($124.5 million), and Montgomery ($300.7 million).

be faced in the upcoming legislative session. Medicaid has taken steps over the last year to enhance existing programs and implement new initiatives to insure every dollar appropriated to Medicaid is spent in the most efficient manner possible to provide as many services to as many recipients as possible. Several areas I would like to highlight for you include the redesigned Patient 1st Program, pharmacy program changes, enhanced program integrity initiatives, and our new web based eligibility application.

Patient 1st Program

As many of you know, Patient 1st is a program designed to create a medical home for Medicaid patients by linking each patient with a primary medical provider also known as a PMP. The patient must either receive services directly from their PMP or receive a referral from their PMP to go to another provider. The goal of Patient 1st is to ensure that patients receive the most appropriate care in the most appropriate setting. Medicaid temporarily discontinued this program in February 2004 because of our inability to demonstrate the program's cost effectiveness to the Center for Medicare and Medicaid Services (CMS). After working with a physician advisory group and with the support of the Administration and the Legislature, we redesigned the program by adding incentives and innovative enhancements. Medicaid then requested approval from CMS to begin the new program under Federal waiver authority. Federal approval was granted in an unprecedented three months after the request was submitted.

The redesigned program maintains the underlying goal of fostering the development of a relationship between Medicaid patients and their primary care physicians. Program enhancements have been made that will encourage appropriate medical care in the most appropriate settings. The areas offering the most opportunity for improvement include addressing inappropriate use of the emergency room and pharmacy prescribing patterns.

Program enhancements include collaboration with the University of South Alabama to place in-home monitoring equipment for patients with chronic diseases. This equipment will monitor the patient's condition on an on-going basis and will help ensure that the patient's condition does not worsen over time without appropriate intervention. Daily reports are provided to the patient's primary physician and problems are monitored by 24-hour nursing personnel. Medicaid's on-going partnership with the Department of Public Health continues in this program. The Health Department's home health nurses and case managers will provide support for both our disease management component and our medical/social case management.

Additionally, Medicaid has partnered with Blue Cross Blue Shield to provide information to physicians about medications a patient is receiving. InfoSolutions, a software program donated by Blue Cross Blue Shield, will provide a wealth of information to physicians. Often a physician writes a prescription for a patient, but the patient does not have the prescription filled or may have medicines from other physicians. Through this partnership, physicians will have access to paid claims information from BCBS and Medicaid so that they can track all medications being taken by a patient.

All of these initiatives are being provided at no additional cost to the State or to physicians.

Pharmacy Program

Medicaid has implemented various pharmacy initiatives over the last year including the Preferred Drug List, brand limit, therapeutic duplication edit, and physician education. Continuation of these initiatives will save approximately $119 million in state funds in FY 2006.[9]

[9] Projected FY 2006 savings of $119 are before federal rebates. Savings net rebate are $101.6 million.

PDL

Legislation passed in June 2003 authorized Medicaid to implement a Preferred Drug List. The Preferred Drug List is developed in consultation with a Pharmacy and Therapeutics (P&T) Committee consisting of practicing physicians and pharmacists from across Alabama representing various specialties. The P&T Committee conducts an in-depth clinical review on each class of drugs and makes recommendations to Medicaid on which drugs should be on the PDL. The PDL includes brand name, generic and over-the-counter (OTC) drugs. Alabama is one of the few states that place clinical decisions for preferred drug status above financial decisions.

Preferred generics and brand name drugs are available without prior authorization; non-preferred drugs are available through prior authorization. Medicaid also has implemented a stable therapy policy for all classes of drugs for children and some classes for adults. This policy allows a patient to continue to use a non-preferred drug if the doctor can document that the patient has been stable on that drug for a period of time.

Savings have been achieved from the implementation of the PDL through greater utilization of preferred brand and generic drugs. FY 2005 represents the first fiscal year for which a full year of savings will be achieved.

Although pharmaceutical manufacturers have the opportunity to offer Medicaid supplemental volume discounts, these discounts are <u>not required</u> to be included on the PDL. In fact, 67% of preferred brands were selected for the PDL when no state discount was offered. Supplemental state drug rebates have been negotiated with pharmaceutical manufacturers in order to obtain preferred status. Negotiations have resulted in a total of $2.1 million being

collected to date.[10] This is in addition to the federal drug rebates that are collected on all covered drugs.[11]

Medicaid implemented an "electronic prior authorization, or "PA" system on December 1, 2004. The design and implementation of this system is a continuing effort to simplify the drug prior authorization process for physicians and pharmacists as much as possible. In less than four seconds, the system electronically reviews pharmacy claims that require prior authorization against paid medical and pharmacy claims to determine if the claims are approvable. If so, the pharmacy claim will pay without the need for any paperwork by either the physician or pharmacist. If the system cannot determine whether all criteria has been met, a prior authorization request will be required.

It is estimated that a minimum of 40% of the current manual prior authorization requests will be handled electronically. Medicaid has implemented this system in 3 drug classes so far, and anticipates full implementation by February.[12]

Brand Limit

Medicaid implemented a limit of four brand name prescriptions per calendar month per recipient on July 1, 2004. Children under the age of 21 and nursing home recipients are exempt from the prescription limit. By federal law, children can not be limited and all non-covered medically necessary drugs must be offset from a nursing home resident's resources. There is no limit on the number of generics or over-the counter prescriptions a recipient may receive.

[10] Rebates are invoiced one quarter in arrears. The state volume discount program started October 1, 2003, and has been expanded as more drug classes are added to the PDL.
[11] Federal rebate collections in FY 2004 were $126.7million.
[12] Implementation includes all drug classes suited for electronic review. Classes requiring medical records, lab values, etc. will not be included in the electronic review process.

Medicaid allows for prescriptions to exceed the four brand limit for anti-psychotic and anti-retroviral medications, but in no case can the limit exceed ten brand name drugs per month.

Beginning November 22, 2004, Medicaid began to allow overrides to the brand limit for very limited classes of drugs[13]. Overrides are granted only in cases in which the prescribing physician documents the medical necessity for the recipient to be switched from one brand drug to another brand name drug within the same therapeutic class in the same calendar month.

Other Pharmacy Initiatives

Therapeutic Duplication Edit

Effective February 19, 2004, Medicaid implemented a Therapeutic Duplication Edit for pharmacy claims. Therapeutic Duplication is the prescribing of two or more drugs from the same therapeutic class such that the combined daily dose increases the risk of toxicity or incurs additional program costs without additional therapeutic benefit. This edit warns pharmacists when a duplicate claim is submitted. The therapeutic duplication edit takes into consideration the exhaustion of previously dispensed medications by calculating the days supply and the dispensed date. To date the edit has been implemented in four (4) drug classes.[14]

Physician Education

Medicaid Pharmacy Specialists provide educational visits regarding pharmacy initiatives to enrolled physicians. Representatives from seven regional areas of the state conduct a

[13] Drugs eligible for an override: Antineoplastic Agents (cancer), Antiarryhthmic Agents (cardiac), Cardiotonic Agents (cardiac), Nitrates and Nitrites (cardiac), Alpha Adrenergic Blocking Agents (hypertension), Beta Adrenergic Blocking Agents (hypertension), Diuretics (hypertension), Potassium Sparing Diuretics (hypertension), Angiotensin-Converting Enzyme Inhibitors (hypertension), Angiotensin II Receptor Antagonists (hypertension), Mineralocorticoid (Aldosterone) Receptor Antagonists (hypertension), Central Alpha Agonists (hypertension), Direct Vasodilators (hypertension), Peripheral Adrenergic Inhibitors (hypertension), Miscellaneous Hypotensive Agents (hypertension), Hemostatics (hemophilia), Calcium Replacements (end stage renal disease), Electrolyte Depleters (end stage renal disease), Immunosuppressives (organ transplants), Alpha Glucosidase Inhibitors (diabetic), Biguanides (diabetic), Insulins (diabetic), Meglitinides (diabetic), Sulfonylureas (diabetic), and Thiazolidinediones (diabetic).

[14] Triptans, Anti-psychotics, Anti-Hypertensives and Narcotic Analgesics.

minimum of 1,500 visits per quarter. Information regarding prescribing patterns and the Preferred Drug List is shared with providers in an effort to foster appropriate and cost effective drug therapy.

Medicare Drug Program

As you are aware, Congress passed the Medicare Modernization Act (MMA) in late 2003. Effective January 1, 2006, the MMA will provide Medicare beneficiaries with access to prescription drug coverage known as Medicare Part D.[15] Unfortunately, there is a lot of confusion about how significantly this new drug benefit will impact states financially. It is uncertain exactly how these programs will be implemented and what requirements will be placed on the state. What is known is that for the first time in the history of the Medicaid program, Alabama will be required to make monthly payments to the federal government for a portion of the drug expenditures for qualified Medicare recipients.

Because of the choice of 2003 as the base year, savings achieved through our PDL and 4 brand limit will not be recognized by the federal government. In addition, Part D providers can limit their list of covered drugs, and change that list at will. If an individual loses coverage of a drug and has an adverse outcome, Medicaid may see an increase in other healthcare costs, such as emergency room and physician office visits. Needless to say, we are monitoring the implementation of this federal program very closely.

Program Integrity

Medicaid has implemented several initiatives to improve administrative efficiencies. In July 2004, Medicaid entered into a contract with Health Watch Technology (HWT), a company that helps healthcare payers use their paid claims data to recover overpayments, address fraud

[15] Approximately 162,000 Alabamians will be eligible for the new Medicare drug benefit.

and abuse, and implement other cost savings programs. The contract requires that HWT conduct post payment reviews for the Medicaid Agency. HWT is paid a contingency fee based on the total dollars collected and deposited.

To date HWT has conducted post payment reviews of all pharmacy claims data, identified potential overpayments of $5.9 million, and mailed a total of 1,145 letters to pharmacy providers. Medicaid has received payments of $1.7 million from pharmacy providers for claims that were billed in error. HWT is in the process of conducting additional post payment reviews for other program areas.[16] Also, this initiative has helped educate providers about appropriate billing practices and on Medicaid policies.

Third Party

The Public Consulting Group (PCG) is working with Medicaid on a third party "look behind" contract to identify third party resources not previously identified by Medicaid. PCG has completed the verification process of their initial data matches with their health plan networks, and furnished Medicaid their first file of 126 new third party resources. PCG will continue to perform data matches with various health plans and furnish new third party data to Medicaid once their verification process has been completed. We also are working with PCG on collection of aged third party accounts receivable and credit balance reviews.

Medicare HMOs

Medicaid also works to reduce costs for our dual-eligible recipients by contracting with the three Medicare Advantage plans that are approved by CMS to operate in Alabama. United Healthcare's Medicare Complete currently operates in 14 counties, VIVA's Medicare *Plus* operates in 4 counties and HealthSpring's Seniors First operates in 13 counties. Under the

[16] Lab – January/February; Pharmacies – March/April; Hospitals and Physicians – June through August; Drug Rebate – July through September.

contract terms, Medicaid pays a capitation fee to the Advantage Plan for dual-eligibles. By paying a monthly capitation fee for eligible recipients, Medicaid avoids paying their Medicare coinsurances and deductibles. This results in a cost-savings to Medicaid of approximately $66 per recipient per month and approximately $6.4 million during FY 2004.[17] Medicaid anticipates greater savings over the next two years with the planned expansion into additional counties by all three Advantage plans.

Medicaid Eligibility and Web Based Application

Medicaid eligibility caseworkers in Alabama have the highest caseload in the nation. In an effort to address this workload and simplify the application process we have taken advantage of as much technology as possible. One of the most significant improvements in this area was the consolidation of applications for various health care assistance programs. Families can now apply on-line for health coverage in Alabama.[18] A joint application for Medicaid, ALL Kids and the Alabama Child Caring Foundation[19] has been developed and can now be filled out and submitted on-line. The on-line web application can be accessed at *www.insurealabama.org*. This application will simplify and make the process more convenient for the family, and more efficient for state agencies.

The on-line web application will make a preliminary determination of eligibility for these programs by pre-screening individuals for Medicaid, ALL Kids, and the Alabama Child Caring Foundation. The applicant has 30 days to complete and submit the application on-line. The family must provide a signed signature page to the appropriate agency to complete the process.

[17] At the end of FY 2004, Medicaid paid capitation fees for 8,824 recipients.
[18] On-line applications are accepted for MLIF, pregnant women, children, and Plan First.
[19] The Alabama Child Caring Foundation is a program that provides services to children who do not qualify for Medicaid or ALL Kids. The Foundation is administered by Blue Cross Blue Shield funded through voluntary and private contributions.

Families will be told on-line which program they appear to be eligible for, and the application data will be automatically forwarded electronically to the appropriate organization for processing. The eligibility worker will make the final determination for eligibility.

The on-line web application was made possible through a Robert Wood Johnson Grant and reflects collaboration between the Department of Public Health, Medicaid, and the Alabama Child Caring Foundation. The project was successfully launched statewide in September 2004.[20]

Funding

CMS

I am pleased to report that Medicaid has made significant progress in resolving outstanding issues with CMS. As many of you know, these issues have plagued Medicaid for over 10 years. CMS outlined 16 issues representing differences between CMS and Medicaid with a potential disallowance of $1.4 billion. 2 items involve the Department of Human Resources (DHR) and are being negotiated separately with DHR taking the lead role supported by Medicaid. Medicaid anticipates the remaining issues will be resolved without Medicaid having to pay back any significant federal funds.

FY 2005 Overview

With no loss of federal funds due to settlements with CMS, and continuation of various program changes implemented during FY 2004 and 2005, I am hopeful Medicaid will make it through this fiscal year. We will face a $4.4 million shortfall due to an unprecedented increase in Medicare premiums[21]. As many of you know, Medicaid is required by Federal law to pay Medicare premiums and deductibles for qualified individuals. In September 2004, we learned

[20] 1,071 applications have been received on-line since the pilot started in July 2004.
[21] Medicare Part B premiums increased effective January 1, 2005. Premium increased from $66.60 to $78.20 per recipient. The Part B deductible has also increased from $100 to $110.

that instead of the 2-3% historical increase in premiums (for which Medicaid budgeted), the premiums were actually being increased by 17%; $4.4 million for FY 2005. I hope that Medicaid will be able to absorb the shortfall through increased savings from existing program efforts. In addition, and with great appreciation to the Attorney General, we collected over $1 million on a nationally settled antitrust claim against a pharmaceutical manufacturer.[22]

FY 2006 Overview

Medicaid has requested $129.1 million for FY 2006 which represents the funding needed to continue Medicaid services and reimbursement at the existing level. This request is based on the continuation of the PDL, the 4-brand limit as currently designed, Patient 1st, program audits and administrative efficiencies.

Loss of IGT

As a result of federal changes, CMS has tightened how states can use Intergovernmental transfers (IGT). These changes have resulted in a loss of $24.4 million for FY 2006.

Inflation[23]

With very conservative estimates, inflation represents an increase of $36.4 million. This inflation calculation considers both the increase in the cost of providing health care as well as the increase in recipients and utilization.

[22] Settlement of $1,070,923 received from Bristol-Myers, manufacturer of BuSpar.
[23] Nursing Homes 4%, Pharmacy 15%, all other programs 3%

Change in FMAP

The good news is that Alabama's economy is improving, but as a result of this good news, the state share percentage required to pull down the federal match has increased from 29.17% to 30.49%, or a loss of $52.4 million.

53rd week provider payroll

Every few years, there are 53 weeks of provider payments that must be made instead of 52. This represents a need for an additional $9.3 million.

Medicare premium increase

Medicare premiums historically increase between 3-4% per year. However, in 2005, the premium increased by an unprecedented 17% representing an increase of $6.6 million.

The only remaining optional programs that Alabama can legally cut are:

1. Eliminate Pharmacy services for adults,
2. Reduce home health visits,
3. Eliminate the adult vision and eyeglass program, and
4. Eliminate the hospice program for non-institutional adults.

Again, Mr. Chairman, I would like to thank you for your leadership and for the support of the Legislature of the Medicaid Program. My presentation and 2004 Medicaid statistics by county are posted on our website at www.medicaid.state.al.us.

I am happy to answer any questions you may have.